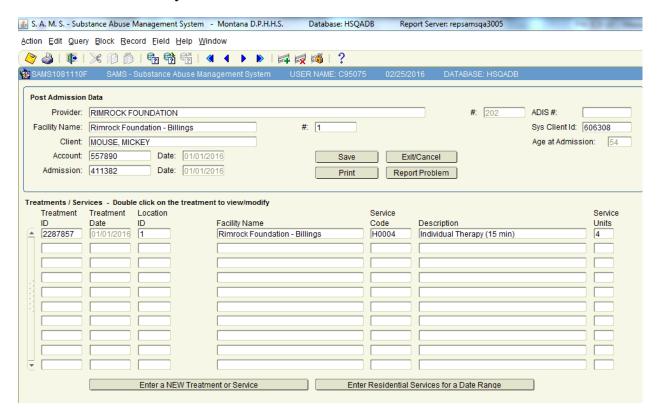# CLIENT TREATMENT SCREEN

## GENERAL PROCEDURES

The Services and Treatments Screen is completed for each client admitted or readmitted into a treatment program with the intention of documenting the specific services and treatments provided to the client.  Services are assigned to each facility and the service records will be used for billing.

Whether you are entering data for a single treatment or a date span of treatment, the information that you will be entering is essentially the same. It consists of the facility identification, date of service or, in the case of date spans, the start and end date for the services being rendered, services performed by, number of units and service code you are billing.

**SAMS allows for 40 days from the Service Date to enter this information into SAMS.**



## SERVICES AND TREATMENT DATA

NAME:  Enter the client's name.  Always use the client's given name.  For example, if the client's name is "Robert" use *"Robert"*, not "Bob".

ACCOUNT NUMBER:  This is a system generated number that will be put on the form after the client information and client admission data has been input and saved.

# CLIENT TREATMENT SCREEN

## MAIN TREATMENT SERVICES

TREATMENT DATE:  Enter the treatment date.  There are eight spaces for the month, day and year.  All spaces **must** be completed.  This is a required field.

> EXAMPLE:    If the current date is June 22, 2008, you would enter:  *06222008*.

PERFORMED BY:  Enter the name of the individual who provided the service.  This is a required field.

SERVICE CODE:  Enter the appropriate service code from the Chemical Dependency Provider Manual.  Service Codes are listed in Appendix C (Section 27).  This is a required field.

UNITS:  Enter the number of treatment units provided for this service.  See the Chemical Dependency Provider Manual for a description of the units.  This is a required field.

OTHER AVAILABLE INFORMATION:  The following is a list of other data elements that you can use.  They are not required.
- People present
- Purpose
- Relation to plan
- Outcome
- Video/lecture
- Schedule description
- Comments

## D.A.P.

PROGRESS NOTES:  The following fields are optional to be used as needed to document treatment.
- Data (Subjective and Objective)
- Assessment
- Plan (Treatment Plan)

## S.O.A.P.

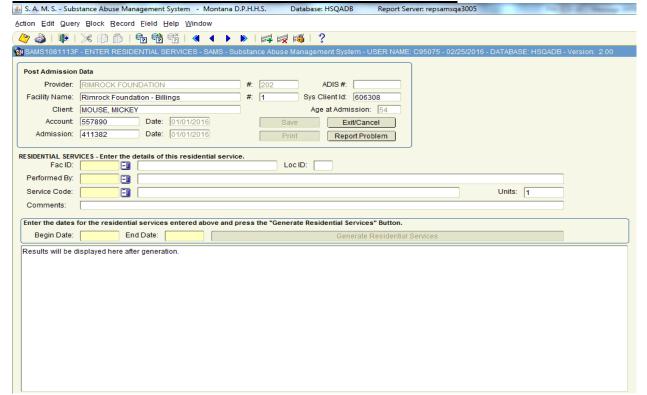PROGRESS NOTES:  The following fields are optional to be used as needed to document treatment.
- Subjective Data
- Objective Data
- Assessment
- Plan

# CLIENT TREATMENT SCREEN

## SINGLE TREATMENT RECORD ENTRY SCREEN



## RESIDENTIAL DATE SPAN ENTRY SCREEN